Supreme Court, U.S.
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No.

In The

Supreme Court of the United States

October Term, 1996

ARROWWEST PHYSICIAN ASSOCIATION,

Petitioner,

vs.

WILLIAM ARDARY, *et al.*,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether state law actions challenging Medicare benefits determinations and seeking consequential damages for denial of Medicare benefits are precluded by the Medicare Act, which requires any individual dissatisfied with a Medicare benefits determination to exhaust the administrative remedies prescribed by the Medicare Act.

PARTIES TO THE PROCEEDING

Petitioner Arrowwest Physician Association ("Arrowwest") was one of the appellees in the Court of Appeals. Arrowwest has no parent or subsidiary companies.[1]

Respondents Aetna Health Plans of California, Inc., Aetna Life Insurance Company, AHP Holdings, Inc., Aetna Health Management, Inc. and Judith Hendrix (collectively "Aetna") also were appellees in the Court of Appeals, and have filed their own Petition for Writ of Certiorari.

Respondents William Ardary, Diane M. Houston, Kevin Ardary, and William C. Ardary, M.D. were the appellants below. They are the surviving family members of Cynthia Ardary, a Medicare beneficiary whose claim for benefits gave rise to this action.

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1. Arrowwest changed its name to Inland Healthcare Group, a Medical Corporation, on January 31, 1995. However, since the group was sued in this action as Arrowwest, petitioner will continue to refer to itself by that name in all papers submitted to this Court.

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Arrowwest respectfully petitions for a writ of *certiorari* to review the judgment of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit, as amended on denial of rehearing and rehearing *en banc*, is reported as 98 F.3d 496 (1996), and is reprinted in Appendix A.

The unpublished opinion of the United States District Court for the Central District of California is reprinted in Appendix B.

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Ninth Circuit was entered on October 21, 1996. Petitioner Arrowwest timely filed a Petition for Rehearing with Suggestion for Rehearing *En Banc*, and respondent Aetna timely filed a Petition for Rehearing and Suggestion for Rehearing *En Banc*, which were denied on December 26, 1996. At that same time, the Court of Appeals amended its October 21, 1996 opinion. This Court has jurisdiction to entertain this petition pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The Medicare Act provides for judicial review of Medicare determinations only under limited circumstances. 42 U.S.C. § 405(g) provides, in pertinent part:

> Any individual, after any final decision of the Commissioner of Social Security made

> after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia.

42 U.S.C. § 405(g) is expressly incorporated into Subchapter XVIII of the Medicare Act, entitled "Health Insurance for the Aged and Disabled," by 42 U.S.C. § 1395ff, which states in pertinent part:

> (a) **Entitlement to and amount of benefits**
>
> The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A or part B of this subchapter, and any other determination with respect to a claim for benefits under part A of this subchapter or a claim for benefits with respect to home health services under part B of this subchapter shall be made by the Secretary in accordance with regulations prescribed by him.

> **(b) Appeal by individuals; provider representation of beneficiaries**
>
> (1) Any individual dissatisfied with any determination under subsection (a) of this section as to —
>
> * * *
>
> (C) the amount of benefits under part A or B of this subchapter (including a determination where such amount is determined to be zero)
>
> * * *
>
> shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that in so applying such sections . . . , any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

In addition, 1395mm(c)(5)(B) specifically incorporates 42 U.S.C. § 405(g) into the statutory provisions dealing with Medicare Health Maintenance Organizations "HMOs"). That section provides in pertinent part:

> A member enrolled with an eligible organization under this section who is dissatisfied by reasons of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 405(b) and 405(g) of this title as provided in this subparagraph, . . . any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

The jurisdictional bar of 42 U.S.C. § 405(h) provides in pertinent part:

> The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings

> of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as provided herein. No action against the United States, the Commissioner of Social Security or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover any claim arising under this subchapter.

42 U.S.C. § 405(h) is expressly incorporated into Subchapter XVIII of the Medicare Act by 42 U.S.C. § 1395ii, which states in pertinent part:

> The provisions of . . . subsections (a), (d), (e), (h), (i), (j), (k), and (l) of subsection 405 of the title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

The regulations implementing the above-cited statutory provisions expressly provide that the jurisdictional limitations and exhaustion-of-remedies requirement apply to denials of benefits for emergency services (such as the airlift transfer at issue in this case), and to challenges to denials of benefits brought by representatives of deceased enrollees. Specifically, 42 C.F.R. § 417.606(a) states in pertinent part:

> An organization determination [*i.e.*, an HMO benefits determination that is subject to administrative appeal by the beneficiary] is any determination made by an HMO or CMP with respect to any of the following: [¶] (1) Payment for emergency or urgently needed services.

42 C.F.R. § 417.610 states in pertinent part:

> The parties to the organization determination are — . . . [¶] (c) The legal representative of a deceased enrollee's estate[.]

STATEMENT OF THE CASE

Arrowwest hereby adopts and incorporates herein by reference the Statement of the Case set forth in the separate Petition for Writ of Certiorari filed by Aetna ("Aetna's Petition") at 3-6. Arrowwest also wishes to furnish the Court with the following additional information regarding Arrowwest's role in this litigation. Arrowwest is an incorporated group of physicians that contracts with Aetna to provide health care services to enrollees of Aetna's Medicare HMO. Thus, when Cynthia Ardary was brought to the emergency department at Bear Valley Community Hospital after suffering a heart attack, it was an Arrowwest cardiologist — acting as Aetna and Medicare's agent — who made the medical determination that Cynthia Ardary could not be transferred by helicopter from Bear Valley Community Hospital to Loma Linda University Medical Center, and who therefore denied authorization for such a transfer to be covered as a benefit of the Aetna Medicare HMO plan in which Cynthia Ardary was enrolled. Arrowwest is the co-defendant referred to in Aetna's petition as having joined Aetna in removing the state court action to the federal district court. *See* Aetna's

Petition at 4. Arrowwest filed a Petition for Rehearing with Suggestion for Rehearing *En Banc* on November 4, 1996, and it was denied on December 26, 1996.

REASONS FOR GRANTING THE WRIT

Arrowwest hereby adopts and incorporates herein by reference the Reasons for Granting the Writ set forth in Aetna's Petition at 7-21. In addition, Arrowwest respectfully submits the following additional arguments regarding the enormous national significance of the issue presented by this petition and, therefore, the compelling need for this Court to grant review of the instant case.

Managed care — whatever its virtues and vices — ***is*** the future of health care in this country. Both the federal Medicare program and the joint federal-state Medicaid program are pushing to enroll as many beneficiaries as possible, as quickly as possible, in managed care plans so that they can attempt to contain spiraling health care costs. Medicare HMO enrollment grew by 25% in 1994, by 36% in 1995, and by 33% in 1996. Prepared Statement of Bruce Vladek, Ph.D., Administrator of the Health Care Financing Administration, before the Senate Finance Committee on "Medicare Managed Care," Federal News Service, March 19, 1997. Medicare beneficiaries are currently enrolling in managed care plans at the rate of ***80,000 per month***. *Washington Health Week*, No. 5, Vol. 5, Atlantic Information Services, Inc., February 3, 1997. According to a recent Congressional press release, the number of Medicare beneficiaries enrolled in HMOs has tripled since 1991, and the Congressional Budget Office predicts that more than one-third of all Medicare beneficiaries will be enrolled in such plans by 2007. "Thomas Announces Hearing on Medicare HMO Regulation," Congressional Press Release, Federal Document Clearing House, February 25, 1997. While there currently are

33 million Americans over the age of 65, in the next century that number will grow to ***more than 77 million***. Prepared Testimony of J. Michael McGinnis, M.D., Member, Partnership for Prevention Board of Directors, before the House Ways and Means Committee Health Subcommittee, Federal News Service, March 13, 1997. Thus, the number of people potentially affected by the decision in this case is huge.

Allowing Medicare beneficiaries to bypass the Medicare administrative appeals process and sue over benefits denials in state court, merely by alleging consequential damages (such as emotional distress), is a prescription for administrative and financial chaos in the Medicare program, at odds with the language and purpose of the Medicare Act and prior decisions of this Court and others, as outlined in Aetna's Petition. Uniformity of decision will become impossible. The ability of the Department of Health and Human Services to contract with HMOs to provide services to Medicare beneficiaries will be severely undermined, because many HMOs may be unwilling to accept such business if they can be sued over every Medicare benefit denial. Moreover, the cost savings achieved by the Medicare HMO system will be consumed entirely by the cost of litigation (and indeed, that cost may far exceed the savings attained through avoiding the provision of unnecessary care — the *raison d'être* of managed care). Such a result will only harm the millions of present and future beneficiaries (and their families) who expect the Medicare program to pay for their health care.

CONCLUSION

For all the foregoing reasons, the Petition for Writ of *Certiorari* should be granted.

Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT
No. 94-56552

William Ardary; Diane M. Houston;
Kevin Ardary; William C. Ardary, MD,
Plaintiffs-Appellants,

v.

Aetna Health Plans of California, Inc., formerly dba:
Aetna Health Plans of Southern California, Inc.;
Aetna Life & Casualty Company; Aetna Life Insurance
Company; AHP Holdings, Inc.; Aetna Health Management,
Inc.; Partners Acquisition Company; Arrowest Physician
Association; Judith Hendrix,
Defendants-Appellees.

Argued and Submitted April 10, 1996.
Decided Oct. 21, 1996.
As Amended on Denial of Rehearing and
Rehearing En Banc Dec. 26, 1996.

Before: O'SCANNLAIN and TROTT, Circuit Judges, and VAN SICKLE, Senior United States District Judge for the District of North Dakota, sitting by designation.

O'SCANNLAIN, Circuit Judge:

We must decide whether state law claims for wrongful death against a private Medicare provider are preempted by the Medicare Act.

I

William Ardary, Kevin Ardary, William C. Ardary, and Diane M. Houston ("the Ardarys") are the surviving husband and children of the late Cynthia Ardary. In July 1991, William and Cynthia attended a presentation given by Judith Hendrix ("Hendrix"), a marketing representative of Aetna Health Plans of California.[1] Because William and Cynthia resided in the relatively isolated community of Big Bear, California, they expressed concern to Hendrix about emergency care and the availability of more sophisticated treatment. Hendrix allegedly told William and Cynthia that should the need arise, Aetna would immediately authorize transfer to a larger facility such as Loma Linda University Medical Center. As a result of Hendrix's presentation, Cynthia, a Medicare beneficiary, enrolled in Aetna's Senior Choice health maintenance organization plan ("Plan"). The Plan was administered by Arrowest Physician Association ("Arrowest") and provided Medicare, major medical and hospitalization, benefits pursuant to a contract with the U.S. Department of Health and Human Services, Health Care Financing Administration ("HCFA").

On May 9, 1993, Cynthia suffered a heart attack. She was taken to the Bear Valley Community Hospital, a small rural facility near her family's home. The hospital had neither intensive nor cardiac care facilities. The Ardarys allege that in spite of repeated requests from her Aetna-approved physician,

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[1] Aetna Health Plans of California, Inc., formerly dba Aetna Health Care Plans of Southern California, Inc., Aetna Life and Casualty Company, Aetna Life Insurance Company, AHP Holdings, Inc., Aetna Health Management, Inc., Partners Acquisition Company, and Judith Hendrix are collectively referred to herein as "Aetna."

Arrowest refused to authorize airlift transportation for Cynthia to Loma Linda University Medical Center.[2] Allegedly because of Arrowest's failure to authorize the airlift, Cynthia died at Bear Valley.

On January 25, 1994, Cynthia's husband and children filed a wrongful death complaint against Aetna and Arrowest in California state court seeking general and punitive damages on the basis of six state law theories of recovery including negligence, intentional and/or negligent infliction of emotional distress, intentional and/or negligent misrepresentation, and professional negligence.[3] The complaint did not seek recovery

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2 At oral argument, Arrowest claimed that they could not certify the transfer under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.A. s 1395dd. EMTALA imposes two requirements on any hospital which participates in the Medicare program: the hospital must conduct appropriate medical screening to a person visiting its emergency room, and a hospital generally may not transfer out of hospital patient whose medical condition has not been stabilized. Brewer By and Through Brewer v. Miami County Hosp., 862 F.Supp. 305 (D.Kan.1994). Whether Cynthia Ardary was stabilized is, of course, a question of fact.

3 The complaint alleges a cause of action against: (1) Aetna, Arrowest and Hendrix for negligence; (2) Aetna and Arrowest for intentional infliction of emotional distress; (3) Aetna and Arrowest for negligent infliction of emotional distress; (4) Aetna and Hendrix for intentional misrepresentation; (5) Aetna and Hendrix for negligent misrepresentation;

(continued...)

of Medicare benefits; however, the Ardarys conceded that their claims were all "predicated on" Arrowest's failure to authorize the airlift.[4]

In February 1994, Aetna and Arrowest timely removed the action to federal court. They argued that removal was proper on the grounds that federal- question jurisdiction existed because the Ardarys' claims all related to the denial of Medicare benefits and therefore were preempted by federal law. Once in federal court, however, Aetna and Arrowest moved to dismiss the complaint under Fed.R.Civ.P. 12(b)(1) and 12(b)(6) for failure to state a claim, on the ground that the Ardarys' exclusive remedy for their action "relating to" the denial of Medicare benefits was the administrative appeals process provided by HCFA. The district court granted the motion to dismiss in a one-page order that provided no reasons for the court's decision. The Ardarys timely appealed.

II

We first consider the Ardarys' argument that the district court erred in finding that the state law claims all related to the denial of Medicare benefits and therefore were preempted by

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[3](...continued)
and (6) Hendrix for professional negligence. Complaint ¶¶ 23-100.

[4] "It is critical to note in this context that the wrongful death action is predicated on the allegation that the benefits were, in fact, owed and were, in fact, wrongfully denied. Moreover, the plaintiffs in such an action will also be required to demonstrate, at trial, that the wrongful denial of benefits was the proximate cause of the death." Appellant's Brief at 20-21.

the Medicare Act, 42 U.S.C. s 1395, with such claims exclusively administered and reviewed by HCFA.

A

The Medicare Act ("Act") is found in Part A of Title XVIII of the Social Security Act, 42 U.S.C. s 1395 et seq. The Act provides insurance for the cost of hospital and related post-hospital expenses, but precludes reimbursement for services which are not "reasonable and necessary" for the diagnosis or treatment of illness or injury.

Section 405(g) of Title 42, which falls within a different section of the Social Security Act, provides for judicial review of old-age and disability claims only after the Secretary of Health and Human Services renders a "final decision" on the claim.[5] Pursuant to 42 U.S.C. s 1395ff(b), this provision is expressly incorporated into those portions of the Act which apply to HMOs. Pursuant to her rulemaking authority, the

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[5] Section 405(g) reads in relevant part: Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides.... The court shall have power to enter ... a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. 42 U.S.C. § 405(g).

Secretary has provided that a "final decision" is rendered on a Medicare claim only after the individual claimant has pressed his claim through all designated levels of administrative review.[6]

In addition, even when judicial review is available it is strictly limited. Section 1395ii of Title 42 applies the proscriptions of 42 U.S.C. s 405(h) to the Act. Section 405(h) states as follows: The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this

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[6] The exclusive administrative appeals process applies to all benefits determinations. 42 U.S.C. § 405(b); 1395mm(c)(5)(A); 42 C.F.R. § 417.606. Such disputes must first be brought for reconsideration to the organization that made the initial determination, 42 C.F.R. § 417.616 and 417.620, and HCFA. 42 C.F.R. § 417.620. If the dispute is not resolved favorably by HCFA, and providing the amount in controversy exceeds $100, a hearing may be requested before an administrative law judge. 42 C.F.R. § 417.630, 417.632. A further appeal may be made to the agency's Appeals Council and, should the amount in controversy exceed $1,000, a dissatisfied party may thereafter seek review in federal court. 42 C.F.R. §§ 417.634, 417.636.

subchapter. 42 U.S.C. s 405(h) (emphasis added).[7] Discussing this provision, the Supreme Court of the United States has held that the appropriate inquiry in determining whether s 405(h) bars federal-question jurisdiction must be whether the claim "arises under" the Act. The Court stated that

> [t]he third sentence of 42 U.S.C. s 405(h), made applicable to the Medicare Act by 42 U.S.C. s 1395ii, provides that s 405(g), to the exclusion of 28 U.S.C. s 1331, is the sole avenue for judicial review of all "claim[s] arising under" the Medicare Act. Thus, to be true to the language of the statute, the inquiry in determining whether s 405(h) bars federal-question jurisdiction must be whether the claim "arises under" the Act.... Heckler v. Ringer, 466 U.S. 602, 614-15, 104 S.Ct. 2013, 2021, 80 L.Ed.2d 622 (1984) (internal citations omitted).

B

This case presents a thorny jurisdictional question: does the Medicare Act, which provides for exclusive administrative review of all claims "arising under" that Act, apply to preclude the heirs of a deceased Medicare beneficiary from bringing state law claims for wrongful death against a private Medicare provider when those claims do not seek recovery of Medicare benefits but instead seek compensatory and punitive damages on the grounds that the provider both improperly denied emergency

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[7] Section 405(h) thus makes § 405(g) the sole avenue for judicial review of all "claim[s] arising under" the Medicare Act.

medical services and misrepresented its managed care plan to the beneficiary?[8]

Resolution of this question turns on whether the state law claims are ones "arising under" the Act. Aetna and Arrowest argue that the entire complaint "arises under" the Act because the Ardarys' claims all relate to a dispute concerning the denial of Medicare benefits.[9] Aetna and Arrowest also maintain that "[t]he courts similarly left no doubt that the Medicare Act precludes all types of civil litigation outside the administrative appeals process" in this case. Appellee's Brief at 12. We disagree with this over-inclusive reading of the "arising under" language.

First, the Ardarys' complaint does not "include any claims in which 'both the standing and the substantive basis for the presentation' of the claims" is the Act. Heckler v. Ringer, 466 U.S. 602, 615, 104 S.Ct. 2013, 2021-22, 80 L.Ed.2d 622 (1984) (citing Weinberger v. Salfi, 422 U.S. 749, 760-61, 95 S.Ct. 2457, 2464-65, 45 L.Ed.2d 522 (1975)) (emphasis added). The Ardarys seek general and punitive damages on the basis of negligence, intentional and/or negligent infliction of emotional distress, intentional and/or negligent misrepresentation, and professional negligence. The standing for these six claims are state common law theories and not the Act. Second, the state law claims are not "inextricably

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[8] The parties do not cite any cases directly addressing the question raised in this case.

[9] Aetna and Arrowest frame the issue as "whether Congress intended to allow the state court actions challenging Medicare benefits determinations when it barred such actions in federal court." Appellee's Brief at 12.

intertwined" with the denial of benefits. Although the Ardarys concede that their wrongful death complaint is "predicated on" Arrowest's failure to authorize the airlift transfer, the claims are not "inextricably intertwined" because the Ardarys are at bottom not seeking to recover benefits. Ringer, 466 U.S. at 614, 104 S.Ct. at 2021. In contrast, the Court in Ringer observed that [i]t seems to us that it makes no sense to construe the claims of those three respondents as anything more than, at bottom, a claim that they should be paid for their BCBR surgery. Arguably respondents do assert objections to the Secretary's "procedure" for reaching her decision--for example, they challenge her decision to issue a generally applicable rule rather than to allow individual adjudication, and they challenge her alleged failure to comply with the rulemaking requirements of the APA in issuing the instructions and the rule. We agree with the District Court, however, that those claims are "inextricably intertwined " with respondents' claim for benefits. Id. (emphasis added).

Although the Supreme Court in Ringer instructed us to read the term "arising under" broadly, it "recognized that in certain special cases, deference to the Secretary's conclusion as to the utility of pursuing the claim through administrative channels is not always appropriate." Id. at 618, 104 S.Ct. at 2023. For instance, the Court commented on one such case, "where the plaintiff asserted a procedural challenge to the Secretary's denial of a pretermination hearing, a claim that was wholly 'collateral' to his claim for benefits, and where he made a colorable showing that his injury could not be remedied by the retroactive payment of benefits after exhaustion of his administrative remedies." Id. (citing Mathews v. Eldridge, 424 U.S. 319, 330-32, 96 S.Ct. 893, 900-01, 47 L.Ed.2d 18 (1976)). Aside from the conclusion that the Ardarys' state law tort claims are not "inextricably intertwined" with benefit determinations, Cynthia's death also cannot be remedied by the retroactive authorization or payment of the airlift transfer.

Aetna and Arrowest argue that Bodimetric Health Services, Inc. v. Aetna Life & Casualty, 903 F.2d 480 (7th Cir.), cert. denied, 498 U.S. 1012, 111 S.Ct. 579, 112 L.Ed.2d 584 (1990), should be read for the proposition that any claim related to the denial of Medicare benefits "arises under" the Act. In that case, Bodimetric Health Services owned and operated home health agencies ("HHAs") that provided in-home medical services. All of the HHAs were certified as Medicare providers which obtained their reimbursements for the medical services from fiscal intermediaries which acted on behalf of HCFA. Pursuant to 42 U.S.C. s 1395h, Bodimetric nominated Aetna to serve as its fiscal intermediary. Under this situation, Aetna provided Medicare reimbursement to Bodimetric's HHAs for services rendered.

Bodimetric alleged that in 1985, the Secretary released a contractor evaluation critical of Aetna's performance. Bodimetric alleged that because of this evaluation, Aetna started regularly to deny Bodimetric's applications for reimbursement so that Aetna would improve its contract performance evaluation and retain its contract with HCFA as a fiscal intermediary. Because of the denials, Bodimetric lost $8 million. Bodimetric then sued Aetna, seeking damages for fraud and other tort causes of action. Aetna moved to dismiss for lack of subject matter jurisdiction, alleging that the exclusive review provisions of the Act barred Bodimetric from pursuing its challenge in federal court, and the district court granted the motion. On appeal, the Seventh Circuit stated that the issue was "whether the allegedly improper application of 'exclusive' review mechanisms to Bodimetric's claim is actionable in the district court." Id. at 482.

The Seventh Circuit noted that "whether Bodimetric's claim for damages is inextricably intertwined with a claim for Medicare benefits or wholly collateral to such a claim (or somewhere in between) depends largely on whether this appeal

more closely resembles United States v. Erika, 456 U.S. 201 [102 S.Ct. 1650, 72 L.Ed.2d 12] (1982) or Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 [106 S.Ct. 2133, 90 L.Ed.2d 623] (1986)." Id. at 484. In Erika, "the Court held that section 1395ff barred judicial review of a hearing officer's 'amount of benefits' determination under Part B of the Medicare Act." Id. However, in Michigan Academy, "the Court concluded that section 1395ff does not bar judicial review of claimant challenges to the validity of administrative regulations promulgated under the Medicare Act." Id. We conclude that the Ardarys' state law claims do not fall under either of the two types of claims reviewed in Erika and Michigan Academy.

The Seventh Circuit concluded that "Erika and Michigan Academy recognized the differences between two types of Medicare claims: challenges to the amount of benefits to be paid are not reviewable, while challenges to the regulatory scheme under which the amount of benefits is calculated are reviewable." Id. at 485. Although the Seventh Circuit properly identified the "differences between two types of Medicare claims," the Supreme Court's decisions in Erika and Michigan Academy certainly do not suggest, at least to this court, that this dichotomy (substantive or procedural) is the standard for making the critical judgment call about what "arises under" the Act. It should be stressed that the Supreme Court has already rejected that "separation of the particular claims ... into 'substantive' and 'procedural' elements." Ringer, 466 U.S. at 614, 104 S.Ct. at 2021.

Without clear guidance from the Supreme Court or Congress on these facts, we must begin with the strong presumption that Congress does not intend to pre- empt state law causes of action with a federal statute. See, e.g., Medtronic, Inc. v. Lohr, — U.S. —- —-, 116 S.Ct. 2240, 2250, 135 L.Ed.2d 700 (1996) ("[B]ecause the States are

independent sovereigns in our federal system, we have long presumed that Congress does not cavalierly pre- empt state-law causes of action."); Cipollone v. Liggett Group, Inc., 505 U.S. 504, 516, 112 S.Ct. 2608, 2617, 120 L.Ed.2d 407 (1992) ("[S]tate law is pre-empted if the law actually conflicts with federal law."); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230, 67 S.Ct. 1146, 1152, 91 L.Ed. 1447 (1947) ("[S]tart with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."). We find nothing in the legislative history to suggest that the Act was designed to abolish all state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA. See Michigan Academy, 476 U.S. at 679-80, 106 S.Ct. at 2140-41. Indeed, the "legislative history of both the statute establishing the Medicare program and the 1972 amendments thereto provides specific evidence of Congress' intent to foreclose review only of 'amount determinations'--i.e., those 'quite minor matters,' 118 Cong.Rec. 33992 (1972) (remarks of Sen. Bennett), remitted finally and exclusively to adjudication by private insurance carriers in a 'fair hearing.' " Michigan Academy, 476 U.S. at 680, 106 S.Ct. at 2141.

We are most reluctant to adopt Aetna and Arrowest's over-inclusive reading of the "arising under" language "without a showing of clear and convincing evidence to overcome the strong presumption that Congress did not mean to prohibit all judicial review." Id. (citations omitted). Absent a strong argument from Aetna and Arrowest, this presumption still remains in force.

Contrary to Aetna and Arrowest's assertions, Bodimetric should not be taken to imply that private Medicare providers and their representatives cannot be held responsible in their individual capacity for tortious acts committed in the context of

the denial of Medicare benefits. The removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients. Aetna and Arrowest's argument that the claims are "inextricably intertwined" with the claim that Cynthia was improperly denied benefits simply misapplies Ringer and Bodimetric on these facts.

Because the instant state law claims do not "arise under" the Act, we hold that the exclusive administrative procedures outlined for resolution of benefit determinations do not preempt the Ardarys' complaint.

III

We next consider whether the district court erred in removing the action to federal court. The Medicare statutes, as applied to an HMO contract, do not, of course, contain a preemption provision. The Ardarys argue that the district court was without jurisdiction because there was no federal statutory preemption of their state law claims, and therefore no substantial federal question was raised. Because we hold that the Ardarys' state law claims do not "arise under" the Medicare Act, we must conclude that the action was improperly removed to federal court. Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 66, 107 S.Ct. 1542, 1547-48, 95 L.Ed.2d 55 (1987).

IV

For the foregoing reasons, the district court's judgment is reversed, and this case is remanded with instructions to the district court to remand the action to state court for further proceedings.

REVERSED and REMANDED with instructions.

APPENDIX B

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

WILLIAM ARDARY, ET AL.,	) CF 94-1235 JSL
	)
Plaintiffs,	) ORDER GRANTING
	) DEFENDANTS'
v.	) MOTION TO
	) DISMISS
AETNA HEALTH PLANS OF CALIFORNIA, INC., ET AL.,	)
	)
	)
Defendants.	)
	)
	)

The Motion of defendants Aetna Health Plans of California, Inc., et al. to dismiss came for hearing regularly on March 28, 1994.

Having reviewed the papers filed in connection with this matter, having heard oral argument, and being fully apprised of the relevant facts and law,

IT IS HEREBY ORDERED that the motion of defendants Aetna Health Plans of California, Inc., et al. be GRANTED.

IT IS SO ORDERED.

DATED: 5/23/94

/s/
J. Spencer Letts
United States District Judge

APPENDIX C

NOT FOR PUBLICATION
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

WILLIAM ARDARY; DIANE M. HOUSTON; KEVIN ARDARY; WILLIAM C. ARDARY, MD, Plaintiffs-Appellants,	)	No. 94-56552 D.C. No. CV-94-01235-JSL
v.	)	
AETNA HEALTH PLANS OF CALIFORNIA, INC., formerly dba: AETNA HEALTH PLANS OF SOUTHERN CALIFORNIA, INC.; AETNA LIFE & CASUALTY COMPANY; AETNA LIFE INSURANCE COMPANY; AHP HOLDINGS, INC.; AETNA HEALTH MANAGEMENT, INC; PARTNERS ACQUISITION COMPANY; ARROWEST PHYSICIAN ASSOCIATION; JUDITH HENDRIX, Defendants-Appellees.	)	ORDER

Before: O'SCANNLAIN, Circuit Judge:

Appellee's motion for stay of mandate pending petition for certiorari to the Supreme Court of the United States is GRANTED pursuant to Fed. R. App. P. 41(b).